MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08959

Reg. Dist. No. 10 5

1. PLACE OF DEATH:

County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 or 6 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Rural — Waldorf
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Berry Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Raymond Adwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lydia Adwell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 29, 1894

8. AGE: Years	Months	Days	If less than one day
51	4	6	____ hrs. ____ min.

9. Birthplace: Caldwell, W. Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Willis Adwell
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Dora Croft
15. Birthplace: W. Va.

16. Informant: Mrs. Lydia Adwell
Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-45 (month) (day) (year)
Cemetery or crematory: Talbot Cemetery
Location: Beckington Nr. Va.

18. Funeral director: Hewitt & Ryon
Address: Waldorf Md

19. 9-5 (Date rec'd by registrar) 19 45 M. L. Mowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4 19 45 at about 7 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 19 45, to — 19 —
and that I ~~last~~ saw him ~~alive~~ on Sept. 4, 19 45

Immediate cause of death	DURATION
Coronary occlusion	minutes
Due to: Coronary artery disease	6 or 7 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Dep. Med. Examiner James L. MacNamara, M.D.
M. D. or other

Address: L. Platz, M.D. Date signed 9-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

08960

Reg. Diat. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: Charles
City or town: La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John F. Burdette

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Emmie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 20 — 1868

8. AGE: Years	Months	Days	If less than one day
76	11		..... hrs. ..... min.

9. Birthplace: Brownsville Md (Town, county, and state)
10. Usual occupation: Fruit Grower
11. Industry or business

FATHER
12. Name: Robert Emory Burdett
13. Birthplace: Brownsville Md

MOTHER
14. Maiden name: Evaline Purdum
15. Birthplace: Brownsville Md

16. Informant: Mrs Robert Norris
Address: La. Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-45 (month) (day) (year)
Cemetery or crematory: Mt Rest Cemetery
Location: La Plata Md

18. Funeral director: Hewitt & Ryon
Address: Waldorf Md

19. Sept 21 19 45 (Date rec'd by registrar) M. P. Miles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 19 45, at 5-30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 19 44, to Sept 19 19 45
and that I last saw h[illegible] alive on 9-19 19 45

Immediate cause of death	DURATION
Uremia	9-10-45
Due to: Sen. Arteriosclerosis	Oct 6-44
Due to: Diabetes	8-10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Medellen M.D. M. D. or other
Address: La Plata Md Date signed: 9-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

8961

★ Reg. Dist. No. 705/100

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Rural — La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En route

Hospital, Institution, or street address where death occurred:
Md. highway # 6

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Dentsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph William Edelen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1922

8. AGE:

Years	Months	Days	If less than one day
23			..... hrs. ..... min.

9. Birthplace: New Port md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Augusta Edelen
13. Birthplace: new Port md

MOTHER
14. Maiden name: Lovenia Juniper
15. Birthplace: new Port md

16. Informant: Leo Edelen Uncle

Address: Lusbrook md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13-1945
(month) (day) (year)

Cemetery or crematory: St Marys

Location: new Port md

18. Funeral director: Smith & Ryan

Address: Waldorf md

19. Oct 11 1945 (Date rec'd by registrar) M. L. Shedd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1945, at 5-45 - 6-00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10, 1945, to ..... 19..; and that I last saw him alive on Sept. 10, 1945

Immediate cause of death	DURATION
Crushed skull	Seconds
Due to: Automobile accident	
Due to: Hit and run car	
Other conditions: Fractured jaw and rt. arm	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-10-45

Where did injury occur? La Plata, Charles, Md.
(City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) Md. State Rd. # 6

Means of injury: Hit by auto Injured at work? No

23. SIGNATURE: Dep. Md. Examiner. James L. MacKenzie, M.D.
M. D. or other

Address: La Plata Md Date signed 9-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

08962

★ Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Spring Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph William Farmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Lucy Farmer
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 9, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	9	hrs. min.

9. Birthplace: Newport, Charles, Md. (town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Hansen Farmer
13. Birthplace: Va.

MOTHER
14. Maiden name: Susan Middleton
15. Birthplace: Va.

16. Informant: Dorothy Farmer
Address: Sp. Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-21-45 (month) (day) (year)
Cemetery or crematory: St Mary
Location: Mrs Port Tobacco
18. Funeral director: Smith & Ryan
Address: Waldorf Md

19. 9-19 (Date rec'd by registrar) 1945 M. L. Mason Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-18 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-14 1945 to 9-18 1945 and that I last saw h... alive on 9-17 1945

Immediate cause of death	DURATION
Congestive Heart Failure	7-10-45
Due to: Arthritis and Anemia	7-45
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Pt Tobacco Md Date signed: 9-19-45

190

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

08963

Reg. Dist. No. 105

FILM No G 98 SEP 11 1945

1. PLACE OF DEATH:

County Charles

City or town Nanjemoy P.O.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several hrs.

Hospital, institution, or street address where death occurred:

Potomac River, Smith Pt.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Nanjemoy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roy Walter Finall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 7-1904

8. AGE: Years	Months	Days	If less than one day
40 4-4-	8	30	..... hrs. ..... min.

9. Birthplace King George Co., Va.

(Town, county and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER 12. Name Samuel Finall

13. Birthplace King George Co, Va.

MOTHER 14. Maiden name Lily Jones

15. Birthplace King George Co, Va.

16. Informant Mr. Boyd Finall (brother)

Address Nanjemoy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-6-45 (month) (day) (year)

Cemetery or crematory Nanjemoy Bobbet

Location Nanjemoy Md

18. Funeral director Hewitt & Ryan

Address Hadley Md

19. 9-5 1945 (Date rec'd by registrar) M. L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3, 1945 at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 4, 1945, to ..... 19..

and that I last saw him alive on Sept. 4 1945

Immediate cause of death	DURATION
Accidental drowning	Minutes
Due to Coronary Thrombosis	Minutes
Due to Essential hypertension	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-3-45

Where did injury occur? Nanjemoy (City or town) Charles (County) Md (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury Became sick in water Injured at work? No

23. SIGNATURE John L. MacKenzie, M.D. Dep. Med Examiner M. D. or other

Address La Plata, Md Date signed 9-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Scott
Scott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08964

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 4 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Hughesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary A Hunter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 23, 1869

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace: Hughesville Chas., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry A. Canter

FATHER — 13. Birthplace: Chas. Co., Md.

MOTHER — 14. Maiden name: Alice Lothoran

MOTHER — 15. Birthplace: Chas. Co. Md.

16. Informant: Mrs. Nellie B. Canter

Address: Hughesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-45 (month) (day) (year)

Cemetery or crematory: Old Fields Chapel

Location: Hughesville, Md.

18. Funeral director: J. Frank Jones

Address: 5406 Ill. Ave. N.W. Wash D.C.

19. 9/20 19 45 (Date rec'd by registrar) Julian H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/45 19 at 11.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 45 19 to 9/20/45 19

and that I last saw h[illegible] alive on 9/19/45 19

Immediate cause of death: Carcinoma Intestines — DURATION: 0

Carcinoma Pancreas — 0

Due to: Uremia Septicemia

Pertussis Hyperpiremia

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leanie S Tucker M. D. or other

Address Hughesville Date signed 9/20/45

68965

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Indian Head Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: #1 D Rd. Penny Wright Homes
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Lee Wilbur Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single.

6.(b) Name of husband or wife: Lfd

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb [redacted] Nov. 21, 1942.

8. AGE: Years	Months	Days	If less than one day
2	10	24	hrs. min.

9. Birthplace: Durham N.C.
(Town, county and state)
10. Usual occupation: Child
11. Industry or business: Lfd
12. FATHER Name: Wilbur Jones Self
13. FATHER Birthplace: Durham N.C.
14. MOTHER Maiden name: Essie Jones
15. MOTHER Birthplace: Durham N.C.
16. Informant: Walter T. McCain
Address: Indian Head. Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept. 26 1945 (month) (day) (year)
Cemetery or crematory: Pomonkey City Cemetery
Location: Pomonkey, Md
18. Funeral director: Penny & Cofer
Address: Hyattsville Md.
19. (Date rec'd by registrar) 9/26 1945 Registrar: Olley Price

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1945, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to Sept 23 1945
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Convulsive Seizure	1 day
Due to: probable Ep. leprsy	1 7 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Susan M. D.
M. D. or other
Address: Indian Head. Md. Date signed: 9/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

8966

★ Reg. Diat. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Chicamuxen.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Chicamuxen.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Swann.

3.(b) Social Security Number —

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Frank Tillman Swann

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Not Known

8. AGE: Years: Approx. 70 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Chicamuxen, Md. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: own Home.

FATHER 12. Name: Not Known

13. Birthplace

MOTHER 14. Maiden name: Not Known.

15. Birthplace

16. Informant: Ollen Swann

Address: Chicamuxen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4 1945 (month) (day) (year)

Cemetery or crematory: Alexander Chapel

Location: Rison, Md.

18. Funeral director: Penny & Cofer

Address: Mason Springs Md.

19. Sept. 4 1945 (Date rec'd by registrar) Mary Sutherland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 19 45, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 40, to Sept. 1 19 45

and that I last saw h alive on 19

Immediate cause of death: Chronic Myocarditis — DURATION: 3 years

Due to:

Due to:

Other conditions: Diabetes Mellitus — 15 years

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank G. Swann M. D. or other

Address: Indian Head. Md. Date signed: 9/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15